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August 12, 2015

Tim Farber
Senior Counsel
Locke Lord LLP
111 South Wacker Drive
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By Email to Tfarber@lockelord.com

Re: Proposed Acquisition of Control of Humana Employers Health Plan of Georgia, Inc. ("Humana") by Aetna Inc. ("Aetna") – Questions Regarding Impact Upon Existing Networks and Provider Agreements O.C.G.A. § 33-13-3(d)(1)(D) and (F).

Dear Mr. Farber:

We received the statement of Aetna regarding the captioned transaction on July 24, 2015 ("Form A"). As you know the Form A is a required filing, the form and substance of which is prescribed in O.C.G.A. § 33-13-3 and Georgia Regulation 120-2-23 (collectively "Review Standards"). As of the date of this letter the Form A is not complete because all of the information necessary to demonstrate compliance with the Review Standards has not been received. Consequently, the 30-day period set forth in O.C.G.A. § 33-13-3(d)(2) will not begin until all such information is submitted to the Georgia Department of Insurance ("Department").

I. STANDARDS RELATING TO THE IMPACT UPON POLICYHOLDERS AND THE INSURING PUBLIC

The Review Standards require the Commissioner to consider the impact of the Form A on both policyholders and the insuring public. Specifically, the following standards are relevant:

> (D) The plans or proposals which the acquiring party has to liquidate the insurer, to sell its assets or consolidate or merge it with any person, or **to make any other**

material change in its business or corporate structure or management are unfair and unreasonable to policyholders of the insurer and not in the public interest;

[…]

(F) The acquisition is likely to be hazardous or **prejudicial to the insurance buying public.**

O.C.G.A. § 33-13-3(d)(1) (emphasis added).

II. CHANGES CONTEMPLATED BY THE FORM A

Upon the acquisition of control of Humana by Aetna there will be material changes to the operational and corporate structure of Humana. Humana and its group operate primarily in the managed care market[1] and deliver managed care benefits through networks of providers who contract to provide services to beneficiaries of a Humana managed care plan. Humana managed care plans provide out-of-network ("OON") benefits as well, which means that there is not a formal contract that governs compensation to the provider for benefits provided to the enrollee and the amount of the benefit is dependent upon a methodology employed by Humana. In addition, Humana maintains a provider network that ensures both the availability and accessibility of benefits through contracted providers.[2] In sum, the benefits that Humana provides to its enrollees are tied directly to its provider network and the related provider agreements that govern the provider relationship with Humana and the enrollee in a managed care plan. Changes to the number and mix of providers in the Humana network, changes to provider agreements, or changes to the calculation of OON reimbursement are clearly changes which would be material. However, such changes are not necessarily unfair or unreasonable to the enrollees nor prejudicial.

III. INQUIRIES

Please respond to the follow inquiries in writing no later than August 28, 2015.

When you are called on to provide an "explanation" you should provide a thorough response that addresses the inquiry. Additionally, you should include copies of any documents that you reference or rely upon in your explanation. Finally, you should avoid interposing statements in your explanation that are not supported by the facts and documents you are submitting in support of your explanation to the following inquiries:

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[1] Managed care market refers to the market for managed care plans. "Managed care plans" means the health insurance policy or subscriber agreement between the enrollee or the policyholder and the health care insurer which defines the covered services and benefit levels available through providers who have contracted with the health care insurer and, in the case of non-HMO plans and emergencies, covered services may be obtained from non-contracted providers (i.e., OON benefits).

[2] See, O.C.G.A. § 33-21-3-(b)(1).

A. Provider Contracts

1. Approximately how many Aetna providers have contracts with Humana? In the following questions such providers are referred to as "Dual Providers."

2. Explain which provider contract will govern the Dual Provider relationship with Aetna after the effective date of the acquisition? If there are relevant provider contract terms that apply to this issue please provide an example copy of the Aetna and Humana contract and a pinpoint reference(s) to the controlling language.

3. Explain what, if any, impact the acquisition will have upon existing providers who only have provider contracts with Humana? If there are relevant provider contract terms that apply to this issue please provide an example copy of the Humana contract and a pinpoint reference(s) to the controlling language.

B. Networks

4. Explain all changes to the existing provider network(s) of Aetna and Humana that will occur as a result of the acquisition of Humana by Aetna, including changes to the existing standards utilized by Humana to determine network adequacy (e.g., time and distance to providers, number of providers, mix of providers, inclusion of specialty hospitals such as children's hospitals). For the purposes of this question, any change to any provider network of Aetna or Humana that will occur, or is reasonably expected to occur, within one year of the effective date of the acquisition is deemed to occur as a result of the acquisition.

5. If you identified any changes in response to question 4, then explain how you will ensure that enrollees are not negatively impacted by the changes. In your explanation you should address continuity of care, reasonable access, adequate number and mix of providers, and how all changes will be communicated to affected enrollees and providers.

C. OON Benefits

6. Some health plans provide OON benefits. The amount of the OON benefits is determined in large part by the amount that any insurer will pay for a particular medical service. This concept is variously termed "Usual, Customary, Reasonable," "eligible charge," "maximum benefit amount," or some other similar term or phrase within the managed care plan. Will the acquisition change how Aetna or Humana calculates the OON benefit? If yes, please explain the change and identify which health plans will be impacted.

D. Impact Upon the Type and Mix of Health Plans Offered by Humana

7. Explain all changes to the existing portfolio of managed care plans currently offered in any market[3] by Aetna and Humana, which will occur as a result of the acquisition of Humana by Aetna. For the purposes of this question any withdrawal or termination of a health plan or market withdrawal that will occur, or is reasonably expected to occur, within one year of the effective date of the acquisition is deemed to occur as a result of the acquisition.

Please feel free to contact me with any questions.

Regards,

/s/ Trey Sivley

Trey Sivley, Esq.
Director of the Division of Insurance and Financial Oversight

Cc: Scott Sanders (via email)
Courtney Faust (via email)
Margaret Witten (via email)
Vince Wiegand (via email)
Jay Florence (via email)

[3] Market means the each of the markets identified in the Department's letter of August 12, 2015 addressing competition.